Based in Churton

A Londoner living in West Cheshire

Plain version, background to Cheshire Lunatic Asylum part 1

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Beginning with nine voluntary institutions, the asylum movement rolled across the 19th century English landscape like an avalanche gathering pace. The 'mentally unsound' were moved in ever greater numbers from their communities to these institutions. From 1808, parliament authorised publicly funded asylums for 'pauper lunatics', and 20 were built. From 1845 it became compulsory for counties to build asylums, and a Lunacy Commission was set up to monitor them. By the end of the century there were as many as 120 new asylums in England and Wales, housing more than 100,000 people.

Historic England: *The Growth of the Asylum – a Parallel World*

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Introduction

As part of my ongoing series looking at Overleigh Cemetery, I asked Christine Kemp of the *Friends of Overleigh Cemetery* about the suicides she knew of in Overleigh Old and New Cemeteries. In the 19th century suicide was more often than not deemed to be the result of temporary insanity. Looking into how suicide was handled in the 19th century lead me to the discovery, probably very familiar to most Chester residents, that there had been a "lunatic asylum" where the enormous site of the Countess of Chester Hospital is now located at Upton.

The Cheshire Lunatic Asylum was a public institution established to house pauper lunatics as well as a limited number of paying private patients in 1829. The asylum opened on a 10 acre site in 1829 to accommodate 45 women and 45 men, reflecting the fairly even numbers of both at asylums in the 19th century. It grew throughout the 19th century and eventually occupied a significant area of over more than 55 acres.

The exterior of the earliest building remains *in situ*, and has the appearance of an elegant and stately Georgian-style building with a small Classical portico, looking very much more like a the remnant of a country estate than the intimidating prison-type establishment that I had been expecting. An elegant façade was typical of 19th century asylums. Today the asylum building is still an active part of the Countess of Chester Hospital, officially named "The 1829 Building" (Grade 2 listed), housing a number of departments including Adult Mental Health, Physical Health and Brain Injury Services, as well as the GP Blood Test Department. When I was sent to the Blood Test department last year it was some consolation that I was being jabbed in

the arm in a place of significant history.

Most of the other buildings associated with the asylum have now been demolished, but nearby are the asylum's 1856 chapel (Grade 2 listed) and the fenced-off and boarded-up remains of what I believe was "the villa," the 1912 building for treating epilepsy (which had been treated as a mental illness up until the early 20th century). The recently restored water tower also remains.

In part 1 (split into part 1.1 and part 1.2 to make it easier to manage, but both posted on the same day) I look at the background history of what were known as lunatic asylums in the 18th, 19th centuries, with some additional comments on how the treatment of the mentally ill changed during the early 20th century. In **part 2** I will discuss the Chester asylum itself, built in 1829, the name of which changed many times over the period of its use as an establishment for treating mental illness. Part 2 has been written and will be posted as soon as I have added in the images, probably next week. **Sources and references** for all parts can be found here.

Many thanks to historian Mike Royden for sharing his knowledge about the Tudor and Victorian Poor Laws and workhouses. You can find out more about Mike's research on his History Pages website.
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18th and 19th century terminology and its limitations

From at least the 17th century the terms "madhouse" and "lunatic asylum" were terms employed to indicate a place that confined the mentally ill. These institutions were differentiated from hospitals that dealt with more conventional medical problems where attempts were made to treat rather than confine patients. The term "asylum" was originally used to refer to places of refuge, retreat and sanctuary, but up until the late-18th century the lunatic asylums were generally custodial in character, often keeping inmates in very poor conditions, and were usually referred to as mad-houses. By the 19th century an asylum was generally an establishment that made claims to treat as well as confine inmates.

Terms such as "mad" and "lunatic," as well as "idiot" and "imbecile" are now considered to be pejorative, as well as imprecise, and are no longer used in medical, psychiatric, sociological, legal or political contexts today. In the Victorian and Edwardian periods, however, these were the standard terms used for those who suffered from some form of mental illness that incapacitated them emotionally or cognitively, temporarily or permanently, along a continuum from violent or otherwise harmful behaviour to mere learning difficulties. The term "insanity" was also in common usage, but has not been entirely excluded from modern usage. All terms are used throughout this post, reflecting the usage of the 18th and 19th centuries.

Insanity in the 18th and 19th centuries could include a vast array of conditions including delusions, paranoia, self-harm, hysteria, mood-swings, visions, speaking in tongues, irrational violence against others, senility, alcoholism, epileptic fits, dementia, mania, depression and suicidal behaviour. Even eccentricity, such as spiritualism or unconventional social behaviour, was sometimes interpreted as incipient lunacy and could

lead to illicit confinement.

The earliest owners and overseers of mad-houses were known as “mad-doctors,” a term from which 19th century asylum owners attempted to distance themselves. The later specialists in mental illness who claimed (and in some cases did) focus on treatment and cure, who were the predecessors of today’s psychologists and psychiatrists, were known as “alienists.” The term derives from the idea of mental alienation.

When the only practical solution to lunacy was incarceration, it should have been a priority to establish a set of universal definitions for the unmanageable symptoms of lunacy, but without a centralized approach to this problem, none were forthcoming. This lack of agreement about what did and did not constitute madness is exemplified by the case of Mrs Catherine Cumming who was abducted from her home and taken to York House Asylum near Battersea in London. After a period of incarceration and a long legal battle, she was declared sane by a jury, and released. When Thomas Wilmot, who had signed her lunacy certificate, was asked what he thought lunacy was, he replied that he had never seen a reasonable definition. One of the most notable features of the Cumming case was the number of medical experts called as witnesses, nineteen of them, including such notable names as John Conolly, Sir Alexander Morison and Dr Edward Monro. As Sarah Wise summarized:

> After the Cumming case, it was once again noted by most commentators how unsatisfactory it was that nineteen eminent medical men could give widely differing opinions of what constituted soundness of mind, tailoring their learning according to what ‘side’ in the dispute had hired them. One alienist had claimed that Mrs Cumming was a monomaniac, another that she was an imbecile, and yet another that she was perfectly sane. . . How safe was anyone when the experts had such divergent views of insanity? [*Inconvenient People*, p.177]

Individual conditions now required names so that patients could be labelled, statistics logged and cases discussed. For example, research by Hill and Laughurne, based on 1870s records from St Lawrence’s Asylum in Bodmin (Cornwall), identified the most common conditions suffered by those admitted at the asylum. Although the main reasons for admission were recorded as mania, dementia, melancholia, moral insanity and the combination of manic behaviour and dementia, it is not at all clear what these terms represent. Hill and Laughurn tentatively apply the following attempts to suggest modern equivalents: mania probably representing overactive episodes; dementia, which appeared to include loss of cognition, memory loss, intellectual deficit, schizophrenia and losses of concentration; melancholia, which seems to have mainly indicated underactive episodes relating to depression; moral insanity (unspecified) and the combination of manic behaviour and dementia, which possibly describes bipolar disorder.

Similarly, a table from the 1855 report for the Cheshire Lunatic Asylum, for both males (M) and females (F), shown below, records that the overarching symptoms in that year were mania, melancholia, dementia and amentia (defined as idiocy and imbecility), and these were further sub-categorized by the presence of epilepsy, general paralysis (also known as general paresis), and suicidal propensity.

Unfortunately, the terms for mental illnesses are not used consistently from one institution to another, meaning that mapping them on to modern conditions can be very difficult. The term dementia, for example, covered a variety of symptoms relating to mental illness at St Lawrence's and Chester, but has become rather more precisely defined today. Epilepsy was subsumed into the general category of mental illness until the later 19th and early 20th century when special epilepsy treatment centres were introduced, intended to be more domestic and less institutional. Suicidal behaviour, with the multiplicity of potential causes and symptoms, even now sits in a somewhat liminal area between mental illness and the ability to make coherent decisions, blurring boundaries.

Another of the many challenges to understanding how lunatics were assessed was that there were no criteria for how a successful cure could be identified. In York the Tuke's compassionate asylum *The Retreat,* it was assumed that anyone who had been released was cured if they were not readmitted, but not only could this represent wishful thinking without additional data, but it sidestepped the task of creating behavioural or other measures that might be used in asylums to determine whether or not someone ought to be released or detained. Like other asylums, the Cheshire Lunatic Asylum annual records show that each year a number of patients were released from the asylum, but it is impossible to know what this actually means, as there are no recorded criteria for determining whether or not a patient had been cured or, for example, sent home because they were not necessarily cured but were not dangerous to themselves or others (usually referred to as "relieved" rather than cured). The failure to define criteria to measure the success of treatment and recovery was a serious problem once patients were certified insane and committed to an asylum, because there was no universal agreement about how recovery could or should be recognized. As well as being imprecise, the lack of clear definitions and criteria was potentially an invitation to corrupt or merely sceptical asylum owners to hold patients indefinitely.

For more on these and other terms see *Historic England's Glossary of Disability History*.
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Practical problems associated with early mental illness

Depending on its severity many forms of mental illness, and conditions like epilepsy that were interpreted as occasional bouts of madness, could be intensely distressing for the families and friends concerned. Not only were the symptoms apparently incomprehensible and might seem to be completely random, but they contravened social norms and conventions in a society that placed great value on normative behaviour. It might be very difficult to manage the situation if symptoms were particularly acute, requiring physical intervention. Mental illness drew unwanted attention, could attract derision and social stigma, and might prevent family members from marrying due to fears of hereditary contamination. Depictions of insanity in drama, literature, art, newspapers and magazines only inflated stigma and misunderstanding. Unfortunately, until the 18th century there was very little official support for mental illness. In rural locations families who could not keep a mentally or otherwise disabled family member at home could pay for their mentally ill relatives, including those with learning difficulties, to be cared by villagers or at local farms in need of income, sometimes providing indigent widows with a means of generating income. There was no official record of men-

tally ill people cared for at home.

Wealthy families could either hire an appropriate person to join the household to care for the afflicted individual, or send them to a private home or a privately run asylum where a frequently unqualified person would charge a fee to take the problem off a family's hands. Families with middle class and reliable working class incomes might depend on any home-based family members, usually female, to provide care, but less expensive privately run houses might again provide a solution. Private mad-houses only began to become prevalent from the 17th century, and operated as lucrative businesses, unlicensed, unregulated and without oversight, there were mad-houses priced for most pockets. They were often owned or managed by individuals with no qualifications and run without any medically qualified person in attendance. Even when operated by physicians or surgeons, these titles covered a multitude of sins and might mean anything from someone who was genuinely attempting to treat ailments to a quack doctor who was little better than a profiteering snake-oil salesman.

For pauper families, a lunatic family member was an even greater burden. Lunatics whose families could not support them were forced to resort to begging. These were amongst the most isolated and vulnerable people in society. The pauper insane were undifferentiated from other paupers, including vagrants, tramps, beggars. Many found themselves in workhouses, and workhouses continued to have a role housing those will mental illnesses well into the 19th century. Other less fortunate pauper lunatics would be incarcerated in prisons, particularly when violent.

The first charitable mad-house was the 1247 Priory of Our Lady of Bethlehem in London, which had taken in the insane from the early 15th century as a monastic duty. For most of its life it was a small institution, with a capacity of few more than 40 individuals, but by the mid 19th century it was suffering from overcrowding. Following the Great Fire of London in 1666 the largest public asylum investment in dealing with lunacy was the 17th century was in the new Bethlehem (also known as Bethlem and Bedlam), which opened in Moorfields on the edge of London in 1676 for 120 patients, with additional extensions added as it reached capacity. Conditions were notoriously dire until the early 19th century.

Outside London care was organized under local parishes in a highly decentralized way, and these would sometimes provide accommodation for those who, through no fault of their own, were unable to support themselves. Charitable asylums began to appear throughout England in the early 18th century, first in Norwich and London, then in Newcastle and Manchester by the middle of the century and, towards the end of the 18th century, others in York, Leicester, Liverpool and Hereford.
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Perceptions of lunacy in society in fiction and theatre

Accounts of madness appear in both Old and New Testaments, where they often provided a moral allegorical aspect to religious narratives. As literacy and theatre became increasingly popular, insanity became a major literary device in drama and poetry from the Elizabethan period. This helped to spread an idea of in-

sanity that was something both alien and dark, but at the same time eerily recognizable in the real world, creating both curiosity and fear. The dramatization of madness appealed to the same sense of fascination, aversion and suspense that horror and science fiction genres generate today.

Many playwrights used madness to add dramatic emphasis to a number of their plays including Christopher Marlowe's *Dr Faustus* (first performed c.1594), Thomas Kyd's *The Spanish Tragedy (first performed 1587),* Shakespeare's *Hamlet* (first performed c.1601), *King Lear* (c.1606), and *Macbeth* (first performed c.1611), Webster's *Duchess of Malfi* (first performed 1614) and John Fletcher's *The Pilgrim* (first performed 1621). The novel *Don Quixote* (c.1605) by Miguel Cervantes, which depicted outright insanity as the main subject matter, was first translated into English in 1612, with a more popular version in 1700. In the 18th century Tobias Smollett also translated Cervantes but also offered his own treatment of madness in *Sir Launcelot Greaves* (1760). Samuel Richardson explored his own versions of female madness in *Clarissa* (1748) and *Sir Charles Grandison* (1753). In the late 18th and early 19th century George Crabbe's poetry makes frequent reference to madness, and his poem *Sir Eustace Grey* (published in his collection of 1807), set in a "mad-house" and framed as a conversation between a patient, a doctor and a physician, examines the decline of a sane person into insanity.

> The more he felt misfortune's blow;
> Disgrace and grief he could not hide,
> And poverty had laid him low:
> Thus shame and sorrow working slow,
> At length this humble spirit gave;
> Madness on these began to grow,
> And bound him to his fiends a slave.

Visual depictions are dominated by William Hogarth's famous *Rake's Progress,* which included a scene showing the Bethlem the asylum as a deranged and frenzied environment viewed by two wealthy ladies visiting the asylum to enjoy a spectacle of curiosity. Although painted in the early 1730s it was engraved in 1755 after which it was widely distributed. Satirical cartoonists, building on the work of Hogarth, became very popular in the 18th century, of whom James Gillray is by far the best known, although there were many others. The satirical publication *Punch* shared many of these, and it was by no means unusual for them to depict politicians and other senior figures as madmen, some of them chained up in lunatic asylums, showing slapstick, scatological and often puerile visions of a flawed society. As Cartoonist Martin Rowson says:

> Personally, I believe satire is a survival mechanism to stop us all going mad at the horror and injustice of it all by inducing us to laugh instead of weep. . . That's why, if we can, we laugh at both those things, as well as being disgusted and terrified by them. Beneath the veil of humour, there's always a deep, disturbing darkness. [The Guardian, March 2015]

References to behaviour that seemed ill-suited to the rational world, particularly amongst politicians and the social elite, were easily ridiculed by reference to lunatic asylums, which played on the fears of society as well

as on its inclination to deride the sane.

Madness was a recurring theme in 19th century literature and British Victorian fictional literature continued to offer insights into how society perceived lunacy. Works include *Jane Eyre* by Charlotte Brontë (1847); *The Woman in White* (1859) and the short story *Fatal Future* (1874) both by Wilkie Collins; Charles Reade's *Hard Cash* (1863); *Dr. Jekyll and Mr. Hyde* by Robert Louis Stevenson (1886), and Oscar Wilde's *The Picture of Dorian Gray* (1891), to name but a few. Insanity also finds its way into many novels and stories by Charles Dickens including the short story *A Madman's Manuscript* (1836, from *The Pickwick Papers*) and the novels *Bleak House* (early 1850s) and *Great Expectations* (1861).

Madness was also featured in opera, particularly adaptations of Shakespeare's plays, and those by Gaetano Donizetti who made particular use of madness as a device. Donizetti's *Anna Bolena* of 1830, in which Anna (Anne Boleyn) goes mad in the Tower of London as she awaits execution, suffering delusions) was premiered in London 1831. Donizetti's 1838 *Lucia de Lammermoor,* based on Sir Walter Scott's 1819 novel *The Bride of Lammermoor,* in which the eponymous heroine goes mad when her brother forces her into a loveless marriage, was first performed in London in 1836, with a famous *Eccola!* mad scene. *Lucrezia Borgia*, dates to 1833 and was premiered in London in 1839. Other well known operas that feature insanity are Vincenzo Bellini's *I Puritani*, in which the heroine goes mad when she is abandoned at the altar and in Wolgang Amadeus Mozart's *Idomeneo* win which the vengeful Elettra, another woman unlucky in love, goes splendidly mad with grief and rage at the end of the opera.

The above-mentioned functional works by Charlotte Brontë, Wilkie Collins and Charles Reade dealt with wrongful detainment, either at home or in an asylum, bringing a new risk to public attention. The impact of these fictional works were considerably exacerbated by real-life incidents of wrongful detainment. Sarah Wise's book *Inconvenient People* provides many examples of illicit incarceration and how these were handled. An early 19th century example is the case of one Mrs Hawley. It is worth quoting James Peller Malcolm's 1808 account in *Anecdotes of the Manners and Customs of London during the Eighteenth Century Including the Charities, Depravities, Dresses, and Amusements etc* to give an example of how the sort of accounts that influenced public perception:

> Amongst the malpractices of the Century may be included the Private Mad-houses. At first view such receptacles appear useful, and in many respects preferable to Public; but the avarice of the keepers, who were under no other control than their own consciences, led them to assist in the most nefarious plans for confining sane persons, whose relations or guardians, impelled by the same motive, or private vengeance, sometimes forgot all the restraints of nature, and immured them in the horrors of a prison, under a charge of insanity. Turlington kept a private Mad-house at Chelsea: to this place Mrs. Hawley was conveyed by her mother and husband, September 5, 1762, under pretense of their going on a party of pleasure to Turnham-Green. She was rescued from the coercion of this man by a writ of *Habeas corpus*, obtained by Mr. La Fortune, to whom the lady was denied by Turlington and Dr. Riddle; but the latter having been fortunate enough to see her at a window, her release was accomplished. It was fully proved upon examination, that no medicines were offered to Mrs. Hawley, and

> that she was perfectly sane.

This incident lead to a Select Committee investigation appointed by the House of Commons to investigate wrongful detention in private asylums, and lead to Madhouse Act of 1774 (on which more later), which recognized the problem and although it did not do nearly enough to tackle it, set a useful precedent for applying legal measures to madhouses. Legislation throughout the 19th century attempted to prevent wrongful certification, but there were four highly publicized scandals on illegal incarceration in 1858 that fuelled public fear and even as late as 1890 laws were being introduced to prevent collusion between those attempting to admit sane patients and certain medical men incentivized to receive them.

The requirements for committing the poor in public asylums were less stringent. This was not an elitist measure. The wealthy were far more vulnerable to family manipulation for self-gain, and as Sarah Wise has demonstrated, men were just as vulnerable in this respect as women. Pauper lunatics whose families had little financial incentive to incarcerate impoverished relatives, except to reduce the pressure on household costs. On the other hand the wealthy were universally treated far more kindly than the poor.

In America, Nellie Bly's late 19th century journalistic account of the ten days she spent on an undercover assignment, incarcerated in an American women's asylum caused a public outcry similar to that attached to the repeated scandals at Bethlem, the York Lunatic Asylum scandals in 1790 and 1814 and the four highly publicized cases of 1858. Bly's experiences were published and widely distributed in book form in 1887. Nellie Bly, the pen-name for Elizabeth Cochrane Seaman, was a correspondent on *The New York World*, and her articles and book served to raise awareness of the true horrors that still existed so late in the 19th century on both sides of the Atlantic.

All these different types of medium demonstrate that madness was a powerful artistic and dramatic device, eliciting feelings of both fascination and dread.
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Approaches to lunacy before 1830

One of the earliest non-fiction books to be published on the subject of mental instability was Robert Burton's (1577 – 1640) startling and difficult 1621 *The Anatomy of Melancholy* which ranges freely through all aspects of religion, the Classics and literature to discuss, in a somewhat tangled narrative, a variety of behaviours that he brings together under "melancholy" that he generally equates to madness:

> That men are so misaffected, melancholy, mad, giddy-headed, hear the testimony of Solomon, Eccl.ii.12. "And I turned to behold wisdom, madness and folly," &c. And ver.23: "All his days are sorrow, his travel grief, and his heart taketh no rest in the night." So that take melancholy in what sense you will, properly or improperly, in disposition or habit, for pleasure or for pain, dotage, discontent, fear, sorrow, madness, for part, or all, truly, or metaphorically, 'tis all one. Laughter itself is madness according to Solomon, and as St. Paul hath it, "Worldly sorrow brings death." "The hearts of the sons

> of men are evil, and madness is in their hearts while they live," Eccl.ix.3. "Wise men themselves are no better." Eccl.i.18.

This is one of many publications that demonstrate that there was no science-based medical understanding of madness before the later 19th century, partly because there was little understanding of human anatomy or neurology, and partly because of the existence of well-honed model of human biology. In the late 11th century the published research of Arab scholars came to the west, where it had a colossal impact on how the world was understood and interpreted, offering new explanatory models that were not dependent on Christian conventions or traditional folklore, but were still woefully inaccurate.

The dominant medical model from the medieval period, echoes of which lasted well into the 19th century, derived from Greek thinking was medical, based on Hippocrates and modifications of Hippocrates by Galen. Forming the foundation of medieval ideas of biology and the treatment of ailments, these beliefs were based on the theory that humans were were made up of four basic elements called humours, which were characterized by specific properties that had to be kept in balance in order for health and well-being to be maintained. Failure to balance these humours was thought to result in illness and/or mental instability. This was a powerful explanatory model that appeared to offer solutions but although it avoided some often unpleasant divine, magical and superstitions approaches, with which it lived side by side, it represented a complete lack of understanding of human biology and anatomy. Various often painful and harmful techniques were employed in attempts to restore equilibrium to these imaginary humours. Some of the treatments were quite literally torturous, intended to draw out or counteract imbalances. Together with explanations citing demonic influence, the humours were an important part of medieval belief that leaked into the 18th and early 19th centuries. Treatments included restraints long periods of isolation and so-called treatments including purging, bloodletting, food deprivation, hot and cold water immersion and beating to attempt to treat madness with physical measures, and presumably to enforce better behaviour.

The issue of whether or not madness could be treated to reduce or eliminate symptoms became a matter of considerable importance to the royal family and the government at the end of the 18th century. Beginning in the 1780s, King George III (1738-1820) experienced phases of severe mental disturbance. This brought with it an interest in research into symptoms of madness at state level. The king's medical team included Francis Willis, a former clergyman who owned an asylum in Lincolnshire. Willis's treatment of King George indicates that the treatments employed in both private and public asylums were genuinely believed to have a beneficial impact because the king was subjected to the same type of treatment practised to rebalance humours, and which Willis used in his own asylum, including ice baths, purging, enforced vomiting, burns, denial of food, and restraints. King George appeared to improve after treatment, and Willis was well-rewarded, but the king's condition worsened again in the early 18900s. In 1810, perhaps because his illness was exacerbated by the death of his daughter Princess Amelia, he withdrew from official duties, although lived for another 10 years.

By far the most common solution for non-royal lunatics was some form of containment. As Lucy Series puts it: "A key tenet of the law of institutions is that some people belong in 'institutions' (at least some of the time)

and others do not." Those institutions were designed to separate the mad from their homes and communities "spatially, legally and socially." It was from the late 17th century in London and the 18th century elsewhere in Britain that the problems associated with madness began to be approached by both private enterprise and, more slowly, charities. Private asylums were unlicensed and unregulated, operating completely outside any legal framework, and as early as 1728 Daniel Defoe (writing under the pseudonym Andrew Moreton) referred to the "vile practice" of incarcerating family members for personal advantage. Operated as commercial ventures, and often very profitable, they grew in great numbers. The new 1676 public Bethlem hospital for 120 patients, was designed by Robert Hooke along impressively grandiose lines but it was poorly constructed and deteriorated rapidly, requiring extensive maintenance and repair. It has become infamous for charging tourists a fee to view the mentally disturbed, a practice not stopped until 1770. It treated the mentally ill as sub-human, barely better than chained animals, and conditions became notoriously dreadful, not tackled until a new reformist superintendent was installed in 1815.

As the 19th century proceeded, lunacy or madness was interpreted in different ways, both medical and philosophical, drawing together the brain, the body and the mind in new exploratory but untested directions. In Britain, as well as elsewhere, physical examination of the skull (phrenology) and the face (physiognomy) were approaches that attempted to find the source of madness in visible physical details, but there was little attempt to develop a scientific understanding of madness or how to treat it. Britain's alienist German counterparts, were more closely affiliated with universities and adopted academic approaches, and developed new ideas towards mental illness in laboratory environments where hypotheses formed and tested. It is in Germany that the term "psychiatry" was first coined in the early 19th century, and from where many of the innovations in understanding mental illness started to emerge. In the late 19th century Emil Kraepelin, Professor of Psychiatry at the University of Heidelberg, recognized and described the mental illness *dementia praecox*, later renamed schizophrenia. This type of research began to influence some British researchers, some of whose own work was recorded in the Journal of Mental Science. Linkages between pathological conditions (such as infectious disease), and mental conditions were only recognized in the later 19th century. For example, the connection between the sexually transmitted infection syphilis and its late-phase symptoms (including mood swings, antisocial behaviour, delusions and seizures) was only recognized in the late 1880s.

There were no medicines available to treat the causes of mental illness. The only medications available were for the treatment of symptoms, not causes. Tranquilizers, a certain amount of pain relief and the treatments for fever were the only available forms of relief for patients. For very violent patients the only measures were sedatives, restraints and isolation.
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The growth of the lunatic asylum 1751-1834

The Old Poor Law (officially the Act for the Relief of the Poor) of 1601 had been instigated during the reign of Elizabeth I was modified but largely changed until the 1834. It classified paupers as the able-bodied who were unable to find employment, the able-bodied who refused to find employment, and those who due to

illness, old age, disability or other infirmities, including lunacy, were unfit for employment and needed relief. In the 18th century the institutional mechanisms available for the mentally ill who had no family assistance were mainly hospitals, workhouses, almshouses, and prisons each set up to cater for different types of problem and accompanying symptoms. Some parishes paid for lunatics to be housed in private house, where they could be confined, but public funding of lunatic confinement was unusual.

The problem of poverty and paupers is well represented by the multitude of poor laws that were introduced throughout the Tudor and Jacobean periods. The church and charitable organizations might assist with payments and household supplies, and even housing for the poor, providing a accommodation and food in return for labour, but such resources were few and far between and did not apply to lunatics. A much more familiar solution for the pauper insane became the workhouse, an early institution initially set up with the laudable intention of helping the poor on a parish by parish basis, partly funded by the "poor rate", and which also took in the pauper insane. Charitable public lunatic asylums, some raised by subscription, were introduced at the end of the 18th century, and became more important as workhouses became more penal in character, but workhouses were still acknowledged places of detention and safekeeping for the insane and the imbecile well into the 19th century.

The **1713 and 1744** Vagrancy Acts distinguished between lunatics and criminals, imposing much less severe treatment on the former, but providing for their detention. In practice, this meant incarceration in a jail or Bridewell rather than a death sentence. In **1723 the General Workhouse Act**, intending to reduce the ongoing costs of maintenance of unemployed paupers, allowed parishes to erect a workhouse, and judge whether those who were out of work should be sent to the workhouse and to labour for their shelter and food. They were built all over Britain in their 100s. Paupers with learning difficulties or mental illnesses were regularly subsumed into the workhouse system due to the lack of any practical alternative. Although anyone could leave, at least in theory, the workhouse was not a place of rehabilitation, and was designed to be sufficiently ghastly to deter people from seeking state help. Some workhouses had a wing for lunatics, but the conditions were very poor. Whilst it probably did lead some to seek work, the system penalized those who were genuinely unable to work.

A new model of lunatic asylums is represented by St Luke's Hospital for Lunatics, founded on Old Street in Cripplegate (London), which opened in **1751**. The neoclassical façade favoured by was emulated by several later institutions. Its first head physician was Dr William Battie, who set himself up in opposition to the barbaric and punitive regime at Bethlem, and published his *Treatise on Madness* in **1758,** describing his contrasting approach. He distinguished between un-treatable congenital madness and that caused by a social environment, which might be treated. He was unusual in preferring treatment to constraint, and although his methods were interventionist, his belief that mental illness was treatable and even curable was influential. He ran a school at the hospital in the hope that this would disperse his teachings and approaches. Although he took in pauper lunatics, Battie ran the hospital as a profitable commercial venture.

The **1774 Act for Regulating Private Madhouses** (and sometimes referred to as the **Lunacy Act** or the **Madhouse Act**) was an early attempt to regulate and manage private madhouses. Public asylums were not

regulated by this Act. One of its achievements was the appointment of five Commissioners who were Fellows of the Royal College of Physicians who would inspect private asylums, and although these were only in the London area it was a step towards certification and licencing. Another important measure was designed to ensure that anyone committed required two referrals by qualified doctors to ensure that individuals were not wrongfully confined by their families.

In **1782** The Act for the Relief and Employment of the Poor (also known as Gilbert's Act) allowed parishes to form themselves into groups for the purpose of building workhouses exclusively for those unable to work. No able-bodied people were to be admitted. Although this was not a successful measure, being entirely optional with a poor take-up, it did acknowledge a real need for providing for the physically and mentally infirm.

As William Battie had demonstrated, real change lay as much in philosophical, ideological and humanitarian ideas as medical and legal ones. The Quaker movement had a strong influence on this idealized way of treating mental illness, and this grew partly out of the death of Quaker Hannah Mills in 1790, less then a month after being admitted to the York Lunatic Asylum (opened 1777), suffering from melancholy. She was one of some 300 inmates who died there in the 37 years between 1777 and 1814. Her case came to the attention of the Quaker and wholesale tea trader William Tuke (1732-1822). Horrified by the facts of the matter, decided to raise funds to build an asylum in which members of the Quaker community suffering from mental health problems could be treated in a new and civilized way. The result was his own asylum called *The Retreat*, which opened in **1792**. His approach, referred to as the "moral" treatment, was altogether more compassionate and empathetic, based on the belief that a positive physical and emotional environment and good food were key to mental recovery. A nurturing and therapeutic approach to care was adopted. Instead of being treated as sub-human or bestial, those who entered the asylum were encouraged to lead lives emulating social norms. Restraint was only used when strictly necessary, and although patients were confined within an institution, the Retreat attempted to reproduced ordinary home living and encouraged socializing amongst patients to help patients to recover. William Tuke's son also worked at the asylum, and his grandson Samuel Tuke (1784-1847), published a description of *The Retreat* in 1813, describing the philosophy and activities of the asylum. This publication helped to inform other mental illness reformers.

Following the **1808 County Asylum's Act** known as "Wynn's Act" after Charles Williams-Wynn, the politician who did much to promote it, Justices of the Peace were given the authority to build county asylums, and to raise finance to do so. This was optional, not compulsory, and local councils were under no obligation to build asylums. Although some new asylums were subsequently built to enable paupers with mental illnesses to be removed from workhouses and placed in appropriate establishments these were slow to arrive. Many who suffered with mental illnesses or learning difficulties continued to be taken into workhouses and prisons. The treatment of the poor continued to be a story of failure to respond to a serious need, whilst the rich were still regularly deposited in private institutions of very variable quality.

In the meantime, the York Lunatic Asylum, first under physician Alexander Hunter, and after his death in 1809 under his assistant Dr Charles Best, continued to take a custodial, punitive and disgustingly neglectful

approach to its patients, a fact that Tuke and other York philanthropists attempted to address, partly by reporting cases to the media and partly by infiltrating the board of governors and using this to demand access to the asylum to inspect patient care, finding that although wealthy patients were usually well treated, pauper lunatics were kept in dreadful conditions. Godfrey Higgins, one of a number of social agitators in York at the time, who had taken a particular interest in the treatment of the insane, used his influence to demand an inspection in March 1814. When he found locked doors he insisted that they be opened, threatening to break them down himself. Inside one room he found female patients in what he referred to as "a number of secret cells in a state of filth, horrible beyond description . . . the most miserable objects I ever beheld." In another part of the asylum he found "more than 100 poor creatures shut up together, unattended and unsuspected by anyone". The case went to court, and a new committee was appointed in 1814, but problems continued to be reported.

The dire conditions at Bethlem in Moorfields continued to be a disgrace to London. Even though a decision had been made to replace the Moorfields building with a new one, south of the Thames at Southwark, matters might have gone on as before if not for Edward Wakefield, a Quaker, like the Tukes, an advocate of lunacy reform whose mother had been confined in an asylum. He had visited the Moorfields site in 1814 and reported on the inhuman conditions that he witnessed there. Wakefield's insights were an important part of the Select Committee investigation of 1815, which reported on the appalling conditions that Wakefield had found.

A sample of Wakefield's contribution to the 305-page report is as follows, which is by no means the most distressing: In the early 1800s it was determined that the Bethlem Lunatic Asylum building in London was no longer fit for purpose, and it was demolished, replaced by a new building in Southwark (which today houses the Imperial War Museum).

> We first proceeded to visit the women's galleries: one of the side rooms contained about ten patients, each chained by one arm or leg to the wall; the chain allowing them merely to stand up by the bench or form fixed to the wall, or to sit down on it. The nakedness of each patient was covered by a blanket-gown only; the blanket-gown is a blanket formed something like a dressing-gown, with nothing to fasten it with in front; this constitutes the whole covering; the feet even were naked. One female in this side room, thus chained, was an object remarkably striking; She mentioned her maiden and married names, and stated that she had !been a teacher of languages; the keepers described her as a very accomplished lady, mistress of many languages, and corroborated her account of herself. The Committee can hardly imagine a human being in a more degraded and brutalizing situation than that in which I found this female, who held a coherent conversation with us, and was of course fully sensible of the mental and bodily condition of those wretched
> beings, who, equally without clothing, were closely chained to the same wall with herself
> . . . .
> In the men's wing in the side room, six patients were chained close to the wall, five handcuffed; and one locked to the wall by the right arm as well as by the right leg; he was very noisy; all were naked, except as to the blanket-gown or a small rug on the shoulders, and without shoes; one complained

> much of the coldness of his feet; one of us felt them, they were very cold. The patients in this room, except the noisy one, and the poor lad with cold feet, who was lucid when we saw him, were dreadful idiots ; their nakedness and their mode of confinement, gave this room the complete appearance of a dog-kennel. [*First report from the Committee on the State of Madhouses,* 1815**,** p.46]

Wakefield himself was appointed as the new superintendent of the new Bethlem in Southwark and he introduced similar values as those employed by the Tukes at *The Retreat*. The new Bethlem opened in **1815** with a wing for the criminally insane, the same year as the Select Committee report on the condition of lunatic asylums.

The **1815** ***First report from the Committee on the State of Madhouses*** of the House of Commons Select Committees highlighted the lack of oversight of lunatics, and the dismal conditions in which patients that pertained in far too many asylums, workhouses and other institutions where lunatics and imbeciles were confined.

The report's findings are elegantly phrased, but make it abundantly clear that asylums, amongst them some of the most successful institutions of the day violated basic human rights. The conditions for paupers and even those of better social standing who lacked visitors to make complaints were frequently filthy places of restraint, beatings and both physical and mental cruelty, with overcrowding, freezing cold conditions, lack of sufficient attendants, and poor admission procedures. Some of the accounts make for really harrowing reading. The most truly depressing aspect of the report is that although the committee had made heartfelt recommendations for improvements, matters remained largely unchanged because these did not pass into law.

Unsurprisingly, matters had not much improved seven years later in 1822 when John Mitford published his eye-opening *A Description of the Crimes and Horrors in the Interior of Warburton's Private Madhouse at Hoxton*. Mitford's assessment of Mr Warburton, unqualified and cruel, concludes that "[on] a careful exposure of this diabolical establishment, I doubt not all will agree with me in opinion, that these 'lawless houses under the law' should be done away with entirely, as a disgrace to human nature. The angel of death moves through them with secret and murderous strides." As with Edward Wakefield's earlier expose of Bethlem in 1815, it is a truly shocking read.

It took another decade before another Select Committee was appointed in **1827**, partly due to a scandal concerning conditions and illegal incarceration at Warburton's Mad-house in Hoxton, and partly due to campaigning by both social reformers M.P. Lord Anthony Ashley (as from 1851 Lord Shaftesbury), and Dorset magistrate Robert Gordon. This time the Committee's reports were taken into account and two new acts were passed in **1828**. The **Act to Regulate the Care and Treatment of Insane Persons in England (also known as The Madhouse Act)** appointed a new Commission in Lunacy to improve centralized control over asylums, not merely in London but throughout England and Wales in an attempt to provide consistent oversight. The Act attempted to tighten up the certification required before a person, either private or pauper, could be admitted to a lunatic asylum, and the Commission was given much greater powers to act in respect

of private asylums. The admission of pauper lunatics now required certification by a Justice of the Peace as well as a physician. **The County Lunatic Asylums (England) Act** again encouraged counties to build asylums from ratepayer contributions, and also required that county asylums should send detailed reports on an annual basis to the Home Office. The Act was updated in **1832**, again to attempt to improve the certification process and prevent illegal detainment, making false or inaccurate certification a misdemeanour.

Following the 1808 and 1828 Acts, several new county asylums had been built. Early examples were Nottingham, Bedford, Norfolk, Staffordshire, Cornwall, Gloucester and Suffolk all before 1830. It is at this point, to slot it into its chronological context, that the new Cheshire Lunatic Asylum was built, in 1829.

Timeline of reform after 1830

After the opening of a number of public asylums in the early 1800s, including the Cheshire Lunatic Asylum in Chester in 1829, several others began to be erected, including those in Dorset, Leicestershire, Shropshire and Montgomery and Devon, all by 1845, the year in which the County Asylums Act was passed. Private asylums still outnumbered county and charity asylums, some small and catering for a handful of patients, whilst others like and Ticehurst in Sussex (opened 1792) the purpose-built Brislington House near Bristol (opened 1806) were fully comparable in size to county asylums.

The most important innovation in the early 19th century had been the “moral treatment” that had been introduced by Philippe Pinet in Paris and by William Tuke in York, was influential on other asylum owners and designers. One of the most innovative of these was Methodist Dr William Ellis. Having learned the practice of moral treatment at the Sculcoates Refuge in Hull, in 1817 he was employed as superintendent at West Riding Pauper Asylum at Wakefield, with his wife Mildred as matron, where he practised the same approaches. His successes led to his appointment at the new Hanwell Asylum in Middlesex in **1832**, with his wife again employed as matron. In each case patients were exposed to conditions that emulated family life and the manners of polite society, with treatment consisting of activities, entertainments and employment both indoors and out, using physical restraints only where strictly necessary. Social reformer Harriet Martineau, was impressed with how, when she visited, she saw a patient going to a garden to work with his tools in his hand, how a cheerful patient rolling in the grass with two other patients had been chained to her bed for seven years before arriving at Hanwell, and in shed in one of the gardens patients were cutting potatyes for seed “singing and amusing each other.” Ellis resigned in 1838 in a disagreement with the overseers of the asylum over their decision to extend the asylum for a much greater patient intake, convinced that his methods could not be successful in a much larger institution, as well as their plans to change how the asylum was managed.

In 1832 the Royal Commission carried out a survey of how the Poor Law was generally implemented throughout all counties, and who benefitted. The findings were published in **1834**, and concluded that existing workhouses and almshouses were too sympathetic and generous, as well as too costly, to be sustainable. The report contained a long list of recommendations that set out to deter paupers from claiming relief by redefining the workhouse as a tool for reducing the costs of caring for the poor. The survey formed the

basis of the new 1834 poor law.

In terms of social reform the new Poor Law, which was introduced to replace the Elizabethan Poor Law of 1601, represented a backwards step. The Act, adding to the 1723 General Workhouse Act and the 1774 Madhouse Act, lead to even more lunatics being absorbed into workhouses, where all inmates were treated far more punitively then before. According to the **1834 Poor Law Amendment Act ("the New Poor Law")** workhouses of a new type would be built to deter vagrancy and the dependency of able-bodied men, women and children on handouts, ensuring that only those who were suffering from desperate necessity would seek a workhouse place. The Act was introduced to reduce the cost of the poor by putting them to work in fixed indoor locations, removing beggars, vagrants and itinerant paupers from the streets, its main mechanism of which was the workhouse. However, although orphanages and infirmaries were also built, the workhouses were punitive places, built to discourage the idle from attending them. They provided deliberately uncomfortable living conditions, splitting of husbands from wives and parents from their children. To enable parishes to finance the new workhouses, the new poor law allowed for the creating of parish unions. Over 350 new workhouses were built within five years of the Act to cope with those who were unable or unwilling to find work.

The 1834 Act also laid down that dangerous lunatics, insane people and imbeciles were not to be kept in workhouses and should be moved to new asylums that should be built without delay, as per the Act of 1828, to receive them. In practice, however, partly because it cost less to house lunatics in workhouses than asylum, and partly because asylums were often overcrowded, an alarming number entered workhouses. In some workhouses special wards within workhouses for the insane were added, and these were often used as repositories for the mentally ill, as well as imbeciles and idiots, the debilitated elderly (particularly those suffering from dementia) and the physically disabled.

The Chester Union Workhouse in 1861, recorded on workhouses.org, included 29 long-term inmates (continuous living for five years or over) of whom nine (31.03%) were deemed to be of "weak mind" and two (6.9%) were "subject to fits" (the latter relevant because epilepsy was considered to be a form of insanity until the late 19th century). Interestingly, the incorporated union of Chester's nine parishes was exempt from the 1834 act, and Chester did not accept a Chester new Poor Law Union until 1869. There is clearly a lot more work to be done in Chester between the lunatic asylum and its workhouses.

New reformist practitioners continued to make their mark in the treatment of lunatics, mainly in private asylums for the wealthy, but also in the county asylums. In 1820 the subscription-funded Lincoln Lunatic Asylum was opened, and in **1837**, under Edward Parker Charlesworth and Robert Gardiner Hill, became notable for being the first English asylum to formally abolish the use of mechanical devices for restraint, with the results recorded in the asylum's annual reports. This approach was influenced by the death at the asylum in 1829 of patient William Scrivinger, who was strapped to his bed overnight in a straitjacket and was found dead from strangulation in the morning. In **1838** Robert Gardiner Hill, who became house surgeon at the asylum, delivered a lecture to The Mechanics's Institute, Lincoln, advocating the care of the mentally ill without recourse to restraints, which was subsequently published and circulated and became influential on

other asylum superintendents who were interested in treating symptoms rather than merely detaining patients.

In **1839** John Conolly moved to Hanwell Asylum in Middlesex to take over from William Ellis as its third superintendent. As superintendent he took Ellis's policy of only using restraints when unavoidable even further, following Robert Gardiner Hell, and in his first report from the asylum claimed that the banning of restraints, replaced by "kindness and firmness" had produced a much better environment for patients. He believed that supervision by specially trained attendants and nurses, consistent regimes and pleasant surroundings were essential. His treatment regime was reported by *The Times* on several occasions, an the asylum was visited by influential figures in society. Although many other alienists were sceptical about non-restraint, the positive publicity soon influenced other asylums who began to follow the lead originally set by Robert Gardiner Hill, but publicized by Conolly. Following his resignation from Hanwell in 1844, after a disagreement with the Metropolitan Commissioners in Lunacy, Conolly published his latest opinions on the subject of managing lunacy. These included his 1847 *The Construction and Government of Lunatic Asylums and Hospitals for the Insane* and his 1856 *The Treatment of the Insane without Mechanical Restraints.* His 1849 *A remonstrance with the Lord Chief Baron touching the case Nottidge versus Ripley* clearly stated his belief that eccentricity, excessive passion, signs of moral failure, gambling what should not be tolerated, and any person's behaviour that was "inconsistent with the comfort of society and their own welfare" were sufficient to merit certification and committal to an asylum. This position was one of intolerance to any behaviour that might contravene strict ideas of social conventions.

The new forms of treatment that attempted to return people to society put great emphasis on the value of manual work, much like the influential 6th century Benedictine monastic ideal, so some asylums built and managed home farms in which patients worked, and indoors encouraged involvement in art, crafts, sewing of clothes and other items of use within the asylum, and help with the maintenance of the asylum buildings. Airing courts provided leisure access to fresh air and vegetation, and sporting activities were arranged. Indoor leisure activities included games, indoor sports, reading material, the ability to engage in art, music, dance and theatre, and there was in-house provision for access to religious guidance

The **1842 Poor Law Commissioners Act** introduced by social reformer Lord Ashley (later Lord Shaftesbury), extended the authority of London's Metropolitan Commissions in Lunacy to the entire country and expanded its staff. Its remit was extended for a trial three-year period to all types of care institution in all parts of England and Wales where lunatics might be held, and this in turn led to the 1844 report of the Metropolitan Commission to the Lord Chancellor. This report described poor conditions and treatment, and expressed concerns about illicit certification and the continued incarceration of those who had recovered.

An indication of how much work still needed to be done to care for the insane was an article published in 1834 by Harriet Martineau, one of Britain's first sociologists, who asked whether lunatic asylums really needed to be as dreadful as they so often were, contrasting it with the pioneering attitude of Dr William Ellis and his wife Mildred at the new Hanwell Lunatic Asylum, which opened in 1831:

> It is commonly agreed that the most deplorable spectacle which society presents, is that of a receptacle for the insane. In pauper asylums we see chains and strait-waistcoats, – three or four half-naked creatures thrust into a chamber filled with straw, to exasperate each other with their clamour and attempts at violence; or else gibbering in idleness, or moping in solitude. In private asylums, where the rich patients are supposed to be well taken care of in proportion to the quantity of money expended on their account, there is as much idleness, moping, raving, exasperating infliction, and destitution of sympathy, though the horror is attempted to be veiled by a more decent arrangement of externals. *Must these things be?* (my italics).

A two year investigation by the Metropolitan Lunacy Commissioners was followed by the 1844 *Report to the Lord Chancellor* which, like its predecessors, highlighted the abysmal conditions in many of the establishments that that housed lunatics: "Twenty-one counties in England and Wales had neither public nor private asylum. Profiteering was rife in the private sector; such public asylums as existed were often defective in terms of site, design or accommodation" [Mellett 1981]. The 1844 report seems to have had rather more significant impact than some of its predecessors, timed as it was with Lord Ashley's continued and vigorous campaigning to provide for pauper lunatics. The *Socialist Health Association* records that in 1844 there were around 20,600 lunatics in some form of institution or private care in England and Wales, of whom only 3800 were private patients. Over 16,800 were classified as paupers.

In **1845,** following the 1844 report, Lord Ashley was able to push through the important **Lunacy Act** and the **County Asylum Act**. Importantly, every county was given compulsory responsibility for the provision of a county asylum funded by rates, instead of making it optional as in the 1808 Wynn's Law. This was a measure that Edward Wakefield, reporting to the 1815 Select Committee had suggested be implemented, and it had taken 30 years for the recommendation to be acted upon. The Act required the transfer of mentally ill people (defined as lunatics and idiots) from workhouses, where over 6000 were recorded in 1847, to these new or existing asylums. It became a legal requirement that both a new Board of Commissioners for Lunacy and regional Justices throughout England and Wales should regularly visit places where lunatics were held, in prisons and workhouses as well as hospitals and both the old and new asylums, for both private and public institutions. Locally appointed Committees of Visitors would oversee the ongoing operation of asylums, and an annual report would be submitted to the Lunacy Commissioners. It was now also a legal requirement that asylums record admissions with basic demographic information about the patient, the reason for admission, details of the disorder, treatments and ultimate outcomes (i.e. discharge or death, including suicide). These were to be inspected at least annually by the Commissioners and regional Justices. In practice, the Act was not supported with funding or resources, and many of its measures proved difficult to implement and enforce, although it was responsible for the growing number of asylums throughout England and Wales. Again, improvements to certification processes were made. In 1847, reporting on their progress, the Commissioners noted how their workload had expanded, emphasising their role as a central resource for asylums:

> We have found it necessary to carry on an extensive correspondence with numerous parties, some demanding· the interposition of our authority, in reference to cases of supposed abuse; many requir-

> ing information, and many others neglecting or misinterpreting· the salutary provisions of the Acts of Parliament; and in the course of this correspondence, numerous questions (some of much nicety and difficulty) have been submitted to us; we have also found it necessary to enter into long and difficult investigations.

The commissioners were undoubtedly patting themselves on the back in this piece of text, demonstrating the value of their new role, but the rest of the report suggests that since the passing of the 1845 Act they had been very busy assessing the network of public and private asylums for which they were now responsible, gathering extensive amounts of data to inform their decisions.

In **1853** John Bucknill (1817–1897) became the first editor of the Asylum Journal, which became the Journal of Mental Science. Bucknill held the position until 1862. The Journal eventually became the British Journal of Psychiatry and is still publishing today. This provided a forum for interested parties, mainly those connected with asylums, to put forward their ideas and instigate discussions. Ideas about madness and lunatic asylums also filtered into the British Medical Journal.

Another set of laws were introduced with the intention of improving matters throughout the second half of the 19th century. The **1853 Lunacy Amendment Act** outlawed hearsay evidence from the process of certification, meaning that doctors were no longer able to depend on the accounts of those who were asking for patients to be admitted to asylums. The certification process required that doctors only included behaviour that they had themselves observed at first hand, another measure towards prevention of wrongful confinement. The **1862 Lunacy Act** enabled patients who had received care for mental illness in the past to enter asylums on a voluntary basis to receive treatment. Special permission had to be sought from two lunacy commissioners, but this recognized that the treatment of mental health should not be exclusively enforced and custodial. It also allowed for greater fluidity of transfer of patients between asylums and workhouses. The Annual Report of the Lunacy Commission for the same year noted that physical restraints were no longer in common use and that isolation was preferred as a viable alternative. In **1867 the Metropolitan Poor Bill** was designed to recognize harmless “imbeciles”, those with learning difficulties in London workhouses and asylums, and to provide them with specialized establishments. In **1874** the rising costs of asylum management were recognized by the government who introduced a grant allocating 4 shillings per week per person sent to the asylum. This presumably also assisted with moving appropriate inmates from workhouses to asylums.

Unfortunately none of the above measures were successful in introducing genuine state-sponsored social responsibility and reform. As late in the 19th century as 1873 the British Medical Association expressed its views on the existing state of asylums:

> There are no public institutions which lie so open to attack as lunatic asylums. They are necessary evils; they interfere with the liberty of the subject; they are costly in erection and maintenance; and they are, as a rule, managed with doors more closely shut than those of other hospitals. There also hangs about them in the mind of the public an air of mystery, and the memory of bygone evils is by

> no means erase. When all these factors of unpopularity are taken into account, it is not difficult to see why the complaints of those who have been subjected to their discipline are listened to with avidity. [BMA August 2nd 1873, p.120]

Sadly, as the century advanced and passed into the 20th century, the number of admissions into asylums increased and the earlier idealistic and more personalized approaches became impossible to implement. The 29th Annual Local Government Report of 1900 stated that in 1860 50% of insane paupers were in county and borough asylums, and 25% of them in workhouses. By 1900 there were 75% in asylums and just under 20% in workhouses.
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Public anxiety about lunatic asylums in the mid-late 19th century

Whilst the role of lunatic asylums was widely discussed in Victorian medical journals and works produced by alienists, each promoting certain methodological and ideological approaches, there were also publications that spoke to the general public, representing concerns with the alienist profession and describing clear infringements of what we would now think of as the human rights of those who had been illicitly incarcerated. Wrongful incarcerations fell into two main categories. First, there were those individuals who had been incarcerated forcibly when sane, sometimes as the result of collusion between family members and medical professionals. Secondly there were those who had been admitted to an asylum under a legitimate certificate, but continued to be detained long after they had recovered their senses. Part of the problem lay in what did or did not qualify as sanity but, as discussed above, there were also cases of malicious incarceration and corrupt collusion for financial advantage.

There were two primary channels of information about such cases to the general public. Both national and local media took up the stories of those who had been illicitly confined in lunatic asylums, whilst some of the victims published their own accounts. Examples of the latter are John Perceval's *A narrative of the treatment experienced by a gentleman during a state of mental derangement* (1840), Rosina Bulwer-Lytton's *A Blighted Life* (1880) and Louisa Lowe's *The Bastilles of England, Or The Lunacy Laws at Work* (1883). Some publications were anonymous, former mad-house inmates fearing derision or stigma. One author, "A Sane Patient," wrote *My Experiences in a Lunatic Asylum* (1879), and another was written by "A Clerical Ex-Lunatic:" *The private asylum: how I got in an out: an autobiography* (1889). As well as describing the circumstances under which they had been admitted and in which they lived, some also urged government change to existing laws.

Although there were exceptions, the means by which the media became aware of such cases was largely via formal inquisitions. In 1858-1859 there were four cases that caused a media sensation and a public panic about illegitimate certification: Rosina Bulwer-Lytton, Mary Jane Hepworth, Reverend William Leach and Lawrence Ruck. Inquisitions were legal mechanisms by which those held in private asylums could apply for permission to take their cases in front of a judge and jury to attempt to prove their sanity. Witnesses could be called to give testimony for or against a patient's sanity, both personal and professional. These were very

expensive and the cost fell on the applicant, so was available only to the very wealthy. Because these people often belonged to elite families or were associated with public figures, they could be of great public interest. Inquisitions were held in public, in any venue large enough to accommodate them, in coffee houses, bars and taverns, and any member of the general public or media was free to attend. Juries were men, often magistrates or others who were sufficiently educated to assess both medical and legal arguments. In the cases of Bulwer-Lytton, Hepworth, Leach and Ruck, all four had been confined in asylums, but during inquisition had been judged sane. Rosina Bulwer-Lytton had a particular gift for publicity and succeeded in winning many newspaper publications to her side to publicize her grievances. The highly publicized scenario where a family member, colluding with an asylum owner and sent attendants to bundle a sane victim into a carriage to be locked up, their basic human rights denied them, caused real public anxiety.

The newspaper publications and first-hand accounts about individual cases were supplemented by the work of pressure groups. Three groups were formed to promote the causes of patients in asylums, more or less consecutively, all started by those who had direct experience of illegal detention in lunatic asylums: *The Alleged Lunatics' Friends Society* (an informal grouping until 1845 when they became organized)*, the Lunacy Law Reform Association,* and its splinter group *The Lunacy Law Amendment Society*. At the same time, Georgina Weldon attracted many followers in her campaign against illegal incarceration and detainment in asylums, having gone into hiding when her estranged husband attempted to have her committed. Whist in hiding she was declared sane by two independent physicians. All these activists wrote letters to influential people, took out newspaper adverts, distributed pamphlets and spoke extensively in public in attempts to influence government action to reform lunacy laws. Although they were rarely successful at pushing through legal reform, they were very good at generating publicity for their causes, drawing attention to the financial motivations of both those who might benefit from certifying a relative and the asylums admitting them, and the callous tyranny of some of the asylum owners and staff. They also acted to take up individual cases where sane people remained locked up in asylums.

Inevitably, in spite of attempts to force through legal and social reform, changes in the law always lagged behind the need for reform. For every energetic reformer there were many more places that continued to follow easier, less labour-intensive means of confinement, and although individual reformers and medical representatives attempted to improve asylum care, there were continuing problems of unnecessary and illegal incarceration and detainment, sometimes as a result of collusion between relatives and asylum owners, causing ongoing anxiety in contemporary society.
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The criminally insane

In 1800 when James Hadfield attempted to assassinate George III in the belief that the death of the king would initiate the Second Coming of the Messiah, he was charged with treason. However he was judged to be *non compos mentis* (not in his right mind) due to severe head injuries incurred during his service as a soldier. This verdict of insanity was followed by the the **Criminal Lunatics Act**, which required that criminal lunatics should be detained in county jails, and lead to the addition of a new criminal wing be Bethlem to

house the criminally insane. A number of high profile cases followed, and in **1840** Edward Oxford fired a pistol at Queen Victoria and Prince Albert as they were travelling in an open carriage on Constitution Hill in London, and although he was tried for high treason, was found not guilty by reason of insanity. He was sent to the criminal wing at Bethlem.

A decisive case was that of Daniel M'Naghten who, **in 1843**, attempted to kill Prime Minister Robert Peel, but mistook Peel's secretary for the Prime Minister, shooting and killing him. M'Naghten suffered from paranoid delusions, thinking that the Tories were persecuting him and were planning to murder him. He was acquitted on the basis of insanity and confined to Bethlem asylum. This lead to the M'Naghten Rule (or M'Naghten Test) which provided criteria for assessing whether or not someone was insane at the time that a serious crime was committed, to assess whether or not someone was criminal liable. Only when the test has been completed in all its parts can a person be deemed to be criminally insane.

One of the best known 19th century inmates of both Bethlem was was the remarkable professional artist Richard Dadd R.A., who was incarcerated first in the ward for the criminally insane in Bethlem in 1843. Dadd, after exhibiting signs of violent and delusional behaviour when travelling in the Middle East went to stay with his parents to recover but, believing that he was acting under the orders of the Egyptian God Osiris, murdered his father whom he was convinced was possessed by the Devil.

These cases paved the way for the establishment of the Broadmoor Criminal Lunatic Asylum, which opened in 1863 in Berkshire, and which remains in use today. Oxford, M'Naghten and Dadd were all transferred to Broadmoor in 1864. M'Naghten died in 1865 but Dadd continued to paint throughout there until his death in 1886 at the age of 68. Edward Oxford, who showed no ongoing signs of insanity, was offered the opportunity to be relocated to Australia in 1867, and duly took up the offer, settling, marrying and living out his life in Melbourne, later publishing a book about the city.

Much of the intention of earlier laws in this respect was re-formalized in the **Trial of Lunatics Act of 1883**, in which any offence committed whilst a person was deemed to be insane, and therefore according to the law not responsible for his actions at the time when the act was committed, a special verdict of not guilty by reason of insanity should be returned. This law was updated several times, most recently in 1991.
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A broken system

In the later half of the 19th century, it was becoming clear that the optimism of both medical and legal professions the 1840s was dwindling fast, and that the asylum system was failing to keep up with demand. The 21st Report of the Commissioners in Lunacy in 1867 indicated that 90% of patients in public asylums were considered to be incurable. Writing only three years later in 1870, Dr Andrew Wynter, former editor of the British Medical Journal, commented that "Our whole scheme for the cure of lunatics has utterly broken down." Although it was convenient to hold large numbers in facilities where they could be dealt with in a consistent and organized way, the numbers of those who entered far exceeded the numbers of those who

left. Overcrowding was a serious problem for most public. The emphasis inevitably shifted from treatment and cure to containment, order and bureaucracy. This succeeded in dividing lunatics from society, but did not address the root cause of the the problem – the analysis and cure of mental illness. Those who might have been treated and restored to their families were lost in the sheer volume of inmates who required maintenance and management. Wynter referred to this as “brick and mortar humanity.”

There were only two practical solutions to overcrowding in asylums. The first was to return non-violent patients to their families or to send them to workhouses. The second was to expand existing asylum buildings and facilities and to build new asylums. Although workhouses continued to take in lunatics and idiots, expansion and new building were the most frequently adopted solutions. It is to this period that the first of the vast dedicated developments were built, with their own water and gas works, their own fire brigades, cemeteries and other urban-type facilities. These were located in rural locations, where asylums could be conveniently separated from the rest of society, and where land was relatively cheap. The earliest examples of these vast enterprises were built to serve London and its environs, and include Colney Hatch in Middlesex (opened in 1849 for 1000 patients), Leavesden and Caterham (both opened in 1870 for 2000 patients each), Caterham, and Claybury County Asylum (opened in 1894, also for 2000 patients).

It was not until nine years later that the **1886 Idiots Act** created specialist asylums for individuals with learning difficulties beyond the London area. Important distinctions were made between lunatics on the one hand and harmless idiots and imbeciles (those with learning difficulties) on the other. The intention was to take the opportunity to care for them and provide basic education and training so that idiots were treated neither as lunatics that needed to be confined nor as indigent vagrants. Following this, the **1890 Lunacy Act** the certification of alleged lunatics was moved to the jurisdiction magistrates as well as doctors. It also made the provision of free mental healthcare available, but as the majority of the population could only access free psychiatric care if they were certified insane and agreed to be admitted to an asylum, the stigma of certification and the requirement for confinement were significant deterrents to people volunteering to receive the help they needed. More than any previous law, the 1890 Act helped to prevent medical collusion to incarcerate patients wrongfully. Whereas only medical certification had been required before, a civic official such as a magistrate or Justice of the Peace was now required to certify madness. The Act also took measures to prevent the licensing of new asylums, aiming to inhibit the further licensing of private asylums, which it was hoped would lead to the eventual demise of the private asylum.

An inspection of the formerly progressive Hanwell in **1893** described depressing conditions, concluding that it would be surprising if any of the patients were to recover given the type of care they were receiving in fairly dismal surroundings. Even more regrettably, the untested idea that mental illness could be passed from one generation to the next fed into the horrible theory of eugenics. New surveys continued to be carried out, reports continued to be submitted and new laws continued to be introduced, modified and implemented, but it is a sad fact that neither medicine nor the government, via changes to the law, managed to provide convincing support for a growing section of society that was still not well-understood.
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After the Victorian period

I have not ventured into post-Victorian approaches to mental health in this post, but it was very far from a story of continual improvement of care and cure. There was still a very long way to go to even begin an understanding mental illness, and to standardize, in a scientific way, the treatment mental illness in psychiatric units. Sigmund Freud's end-of-century theories of psychology were squabbled over for decades. The First World War's executions for "shell shock" as a judgement of cowardice remain deeply shaming. In the inter-war years psychiatrists began to take a more experimental and interventionist approach to treating mental illness. Several new so-called "heroic" physical therapies were introduced, based on the belief that mental illness had a physical basis in the nervous system or the brain. These included insulin coma, chemical shock, electro-convulsive shock therapies and, most radically interventionist, lobotomization. Egas Maniz's experiments with prefrontal lobotomy remain profoundly disturbing.

It will come as no surprise to those who follow the news that there are still serious problems, not merely in official provision of mental health care, but in care homes for the elderly, including those recuperating and convalescing, and those who had been persuaded to hand over power of attorney. There were dreadful examples of people being released from long-term incarceration in the 1950s and 60s who had been admitted for minor criminality and socially disruptive behaviour, and although they had become institutionalized were found to be completely sane. The use of vast repositories for the mentally unwell was abandoned without, however, a clear strategy for handling those who still needed help. This was followed by a policy of caring for the mentally unwell within the community, pushed through during the 1980s, which often failed to provide families and local care centres with sufficient resources to make this fully viable, placing great strain on families and support mechanisms. The tyranny of some institutions was revealed in a number of scandals and was a theme explored in relatively modern times in the 1975 film *One Flew Over the Cuckoo's Nest*. Documentaries in care homes in recent times demonstrate how this problem still persists in some places.

Today the madhouse or lunatic asylum has become a psychiatric hospital or a psychiatric unit in a general hospital for those with manageable symptoms, or a specialist secure facility for the violent and criminally insane. In the Victorian period medical understanding and psychiatric ideas were only beginning to be proposed and tested, and this continued well into the Edwardian period and beyond, with medicine and the law both playing important parts in how mental illness and suicide were understood, diagnosed and treated. The research remains ongoing. There is still no viable solution, or set of solutions, to the problem of coping with mental illnesses. The subject of how to care for those suffering from mental illness is far from resolved.
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Final Comments on parts 1.1 and part 1.2

In spite of being divided into two parts to make it easier to digest, this quick and dirty summary of the state of mental healthcare in the 18th and 19th centuries inevitably smooths out some of the kinks in that often convoluted story, over-simplifying some of the many subtleties. This account represents a very short summary of a very complex topic.

From the late 18th century mental illness represented a growing issue for a society that was developing a broad social conscience. In spite of many reforms to poor laws and a number of new Acts of Parliament to govern asylums, governments were slow to respond to either public pressure or their own specially commissioned reports, and stories of unlawful detainment in some places and frightful conditions in others failed to produce change that was both meaningful and timely. The role of workhouses in the handling of the mentally ill continued to be important, with patients shared between workhouses, workhouse infirmaries and asylums, in spite of legislation designed to make the responsibilities of each much more transparent, which is an area that needs to be much better understood. It was only towards the end of the 19th century that those with learning difficulties, termed imbeciles and idiots, were seriously treated in the law as a separate problem requiring different types of care. The topic of children in lunatic asylums is not much discussed, but records show that at least some were admitted, as they were to workhouses.

Sometimes those who were supposed to represent the pinnacle of care and reform are described with a rose-tinted filter. For example, Edward Long Fox and his sons, running one of the most expensive private asylums in the country, were accused in the writings of patient John Perceval, son of the murdered prime minister Spencer Perceval, of incarcerating their more troublesome patients in truly dreadful conditions where they were subjected to beatings, threats, manacles, strait-vests, freezing water baths and other punishments and indignities. The alienist John Conolly, a national figurehead of ethical and human approaches, was found guilty in court of taking money for signing legally binding certificates that retained patients in private asylums to which he was employed as a paid consultant. One of these patients was found, by jury to be sane and the investigation highlighted the risk of consultants being paid by asylums for certifying patients. He also often took credit in public for introducing non-restraint in England, in fact an innovation of Robert Gardiner Hill at Lincoln, and at Hanwell asylum had a very low cure rate. Another example is Lord Ashley, later Lord Shaftesbury, generally and fairly acknowledged as an important voice for mental health-care reform but sometimes remarkably intransigent. He often blocked or delayed changes that would have made important differences that would have lead to improved quality of life and greater transparency and justice in the asylum system. This was a particular problem given that Ashley had been elected the lifetime head of the Commission for Lunacy, a position that he did indeed hold until his death in 1885.

By the end of the century the dream of personalized care of the mentally ill by engaging them in social activities within attractive contexts was largely abandoned. The “moral treatment” approach had depended not only on sufficient numbers of attendants to manage patients with kindness and empathy, but those who had a genuine interest in caring and treating. The 1870 Annual Report of the Lunacy Commission recorded that 122 attendants had been dismissed in 1869 for manhandling patients roughly or violently, and it is not at all surprising that as new patients were admitted in increasing numbers, the sheer volume proved difficult to manage:

> The number of people certified as ‘insane’ soared. The asylum created demand for its own services. Less and less people ever left, and more and more arrived. In 1806 the average asylum housed 115 patients. By 1900 the average was over 1,000. Earlier optimism that people could be cured disappeared. The asylum became simply a place of confinement. [*Disability in Time and Place*, Historic

England, Simon Jarrett]

Governments as well a local organizations began to invest in creating larger institutional solutions for paupers whose symptoms indicated the sort of social deviance and/or danger to self that could not be countenanced without intervention. However. the recognition of mental illness and the acceptance that it should be handled by the state caused its own problems as more people were incarcerated and management of mental illness became, like contemporary prisons, more of an issue of how to maintain order than how to provide cures. Unlike most prison sentences, there was no release date for mental patients, who could be held indefinitely and sometimes were. An indication of how urban areas in Britain were overwhelmed by demand was the new Metropolitan District Asylum built between 1868 and 1870 as Leavesden Hospital in Hertfordshire, which was designed to house 1500 patients, after which it continued to expand to cope with the ever growing need to provide care for the mentally ill. Like other asylums of this period, it is more like a small town than a hospital. Sadly, many asylums once again became associated with confinement and bureaucracy rather than attempts at cure and rehabilitation.

The perception of mentally ill people changed over the course of the Victorian and Edwardian periods as psychiatry developed as a specialist branch of medicine, swinging between biological, congenital and neurological explanations on the one hand and emotional-psychological explanations on the other. The degree of subjectivity lead inevitably to disagreement and contradictory opinions, with very little indication of how to choose between the variety of different ideas held in different asylums. The legacy of 19th century mental health medicine, law and care seems to be one of a continued struggle to fully comprehend the complexities of mental illness or to devise suitable ways of treating them sustainably. As Mike Jay says in his book *This Way Madness Lies*, “While the asylum as an institution is now largely consigned to the past, many of the questions it struggled so hard to address still persist.”

Click here for the references for this post

Please click here to go back to Part 1.2. The Cheshire Lunatic will be tackled in **Part 2**. Sources and references can be found here.

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